DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/11/13

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445390	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKETT CARE AND REHABILITATION CENTER	129 HILLCREST DRIVE BYRDSTOWN, TN 38549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on records review, it was determined the facility failed to properly inspect and test the sprinkler system as required. The findings included: 1. Records review on 2/19/13 at 10:55 AM revealed the facility was missing quarterly sprinkler inspections from the second and fourth quarters of 2012. 2. Records review on 2/19/13 at 10:58 AM revealed the facility failed to provide documentation of the five year obstruction investigation. These findings were acknowledged by the maintenance director and the facility administrator during the exit conference on 2/19/13.	K 062	K062 **Corrective Actions** While the evidence documentation was missing during the survey, copies of quarterly sprinkler inspections (as mentioned on the 2567) were recovered, placed in the maintenance log, and faxed to the Fire Marshall by the Maintenance Supervisor on 2/19/13. An obstruction investigation of the sprinkler system is scheduled to be conducted by Century Fire on 3/8/13. **Measures to prevent reoccurrence:** As a means of documentation back up, Century Fire has provided a web site of available inspection records. In addition, a scanned electronic copy of the Maintenance logs will be kept on the business office computer. A calendar trigger was placed on the business office computer by the Administrator on 3/7/13 to remind Maintenance when obstruction investigations are due for scheduling. Scheduling will be done by the maintenance supervisor. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report sprinkler and alarm safety findings to the Safety Committee.	3/8/13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 066	Continued From page 1 area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility did comply with applicable smoking regulations. The finding included: Observation on 2/19/13 at 10:12 AM revealed there was no metal container with self-closing cover device into which ashtrays can be emptied in the smoking area. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 2/19/13.	K 066	**K 066** **Corrective Actions for residents affected:** A metal container with self-closing lid was purchased and placed in the smoking area for use on 3/5/13 by the Maintenance Supervisor. **Measures to prevent reoccurrence:** The Maintenance Supervisor conducts a monthly safety walkthrough that will include examination of the smoking area for required equipment. Maintenance, repairs, or replacements will be facilitated by the facility Maintenance Supervisor as needed. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings of smoking area inspections to the monthly safety committee.	3/5/13
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067		

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K 067	Continued From page 2 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility was unable to maintain negative air pressure in required areas. The finding included: Observation on 2/19/13 at 9:34 AM revealed the door to the janitors closet in the Hope House Hall did not have a self-closure device on it. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 2/19/13.	K 067	**K 067** **Corrective Actions for residents affected:** A self-closure device was installed on the Hope House Janitor's closet door by Maintenance on 3/5/13. The device was confirmed to close to latch by the Administrator on 3/5/13. **Measures to prevent reoccurrence:** The Maintenance Supervisor conducts a monthly safety walkthrough that will include examination of janitor closet doors for self- closure. Maintenance, repairs, or replacements will be facilitated by the facility Maintenance Supervisor as needed. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings self-closing doors to the monthly safety committee.	3/5/13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 55 Standard for the Storage, Use, and Handling of Compressed and Liquefied Gases in Portable Cylinders 6-6 Securing Cylinders. Compressed or liquefied gas cylinders in use or in storage shall be secured to prevent them from falling or being knocked over.	K 130		

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K 130	Continued From page 3 Exception No. 1: Compressed gas cylinders in the process of examination, servicing, and refilling. Exception No. 2: At cylinder-filling plants and distributors ' warehouses, the nesting of cylinders shall be permitted to secure cylinders. NFPA 101 Life Safety Code 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire Barriers. 8.2.3.2.4.1* Openings in fire barriers for air-handling ductwork or air movement shall be protected in accordance with 9.2.1. 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts	K 130	K130 **Corrective Actions for residents affected:** The old caulking as mentioned in the 2567 was removed by the Maintenance Supervisor and replaced with approved fire rated caulking on 3/6/13 and the finding was corrected. **Identification of residents with potential to be affected:** On 3/6/13 the Maintenance Supervisor examined all other firewalls for penetrations and improper caulking with no other findings. **Measures to prevent reoccurrence:** The Maintenance Supervisor will conduct semi-annual checks of the condition of the firewalls. These checks will include and examination of the caulking to ensure continued compliance. In addition, Maintenance Supervisor will conduct post construction checks should outside vendors be contracted for labor related assignments that potentially involves penetrations to the building's firewalls. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings and corrections subsequent to assigned compliance rounds to the Safety Committee.	3/6/13

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K 130	Continued From page 4 shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose. Based on observations, it was determined the facility failed to comply with the Life Safety Code and National Fire Protection Association 55. The findings included: 1. Observation on 2/19/13 at 10:09 AM revealed a helium tank in the activities closet in the dining room was unsecured. 2. Observation on 2/19/13 at 10:29 AM revealed penetrations in the fire walls and penetrations sealed with products other than fire rated caulk in the following locations: Fire wall leading to Hope House Corridor, Fire wall leading to Harmony House corridor, and Firewall leading to Have House corridor. These findings were acknowledged by the maintenance director and the facility administrator during the exit conference on 2/19/13.	K 130	K130 Continued **Corrective Actions for residents affected:** The helium tank sited on the 2567 was re-secured on 2/19/13 by the Maintenance Supervisor as a means of correction. **Identification of residents with potential to be affected:** A paddle-lock was installed to the chain that secures the tank on 2/19/13 by the Maintenance Supervisor to prevent any incident of non-compliance. Removal or transfer of the tank will require notification of the Maintenance Supervisor. Moreover, Activities Staff (those responsible for the helium tank) were inserviced on the requirement for tank security by the Maintenance Supervisor on 2/19/13. **Measures to prevent reoccurrence:** The Maintenance Supervisor conducts a monthly safety walkthrough that will include examination of helium tank to insure that the tank is secure. As already mentioned, Activities staff have been trained by the Maintenance Supervisor that the Helium tank must be secured to the wall at all times. They have been asked to notify the Maintenance supervisor for correction in needed. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings of monthly walk through which will include gas tank security to the monthly safety committee.	2/19/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	Continued From page 5 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure electrical equipment is maintained in accordance with NFPA 70. The finding included: Observation on 2/19/13 at 9:54 AM revealed an oxygen concentrator plugged into a power strip in room 125. This finding was acknowledged by the the maintenance director and the facility administrator during the exit conference on 2/19/13.	K 147	K 147 **Corrective Actions for residents affected:** The extension power cord was removed (and confiscated) from the Oxygen concentrator and plugged directly into a wall plug by the Maintenance Supervisor upon the finding on 2/19/13. **Identification of residents with potential to be affected:** The Maintenance Supervisor conducted a walk through to insure that no other concentrator was plug into an extension power strip on 2/19/13 with no other findings. **Measures to prevent reoccurrence:** The Maintenance Supervisor provided instruction for the Respiratory Therapist regarding the prohibition of power cords for oxygen concentrators on 2/19/13. Training for all nursing staff will be conducted for on 3/8/13 regarding the prohibition of power cords for oxygen concentrators by the Maintenance Supervisor. In addition, regular nursing team rounding will include observation of oxygen concentrators to confirm proper electrical plugging with corrections made if needed. **Monitoring of Corrective Action:** As a means of Quality Assurance the Director of Nursing will report the aforementioned findings to the monthly safety committee.	3/8/13